Aetna Better Health of Florida

Monthly Claims Training- September

Nazdar Shwani

aetna®

September 29, 2020

Learning objectives

As part of your Aetna Better Health of Florida's monthly claims training, we will

- Discuss the timely access standards
- Review updates to immunization codes for Florida Healthy Kids and Medikids
- Review the Aetna Better Health of Florida's updated clinical policies
- Explain the obstetric (OB) prior authorization requirements
- Discuss the common claims errors

aetna®

Appointment Access

Timely access standards

Practitioner type	Appointment type	Accessibility standard
Primary Care Practitioner (PCP)	Preventive care & routine (non- urgent)	Within thirty (30) days of a request
	Urgent care	Within forty-eight (48) that do not require prior authorization or within ninety-six (96) that do require prior authorization
	Non-urgent	Within thirty (30) days of a request
	Emergency services – non-life threatening	Immediately or referred to ER facility
Specialty Referral	Preventive care & routine (non- urgent)	Within sixty (60) days of a request after the appropriate referral is received by the specialist.
	Urgent care	Within forty-eight (48) that do not require prior authorization or within ninety-six (96) that do require prior authorization
	Non-urgent	Within thirty (30) days of a request after the appropriate referral is received by the specialist.
	Emergency services-non-life threatening	Within 24 hours
Behavioral Health/Substance Abuse	Preventive care & routine (non- urgent)	Within seven (7) days post discharge from an inpatient behavioral health admission for follow-up behavioral health treatment or within fourteen (14) days for initial outpatient behavioral health treatment
	Routine/follow-up (non- urgent, symptomatic conditions)	Within seven (7) days post discharge from an inpatient behavioral health admission for follow-up behavioral health treatment or within fourteen (14) days for initial outpatient behavioral health treatment
	Urgent care	Within forty-eight (48) that do not require prior authorization or within ninety-six (96) that do require prior authorization
	Emergency Services-non-life threatening	Within forty-eight (48) that do not require prior authorization or within ninety-six (96) that do require prior authorization
Lab and Radiology Services	Preventive care & routine (non- urgent)	Within fourteen (14) days of a request
	Urgent care	Within forty-eight (48) that do not require prior authorization or within ninety-six (96) that do require prior authorization

aetna

Immunization Codes

Immunization codes

Effective July 1st, Aetna Better Health of Florida has implemented a new payment methodology for vaccines administered to its Florida Healthy Kids and MediKids members only.

All vaccines not covered by Vaccines for Children (VFC) will be reimbursed at 100% of the vaccine's wholesale acquisition cost (WAC).

Providers will receive reimbursement that aligns with the current market price for vaccines, and in most cases, will result in additional payment to providers.

.

What you need to know

- Your reimbursement for vaccines will not change if:
  - Your current contracted rate(s) for vaccines is based on a negotiated flat fee
  - Your current contracted rate for vaccines is based on a different percentage of WAC
- Your reimbursement for vaccines will change if:
  - Your current contracted rate for vaccines is based on a percentage of the Title XXI Immunization Fee Schedule
  - Your current contracted rate is based on a percentage of Average Wholesale Price (AWP)
- Providers must include the appropriate National Drug Code (NDC) number for each vaccine billed on the claim to ensure proper payment
- Providers must ensure that the NDC is cross walked to the appropriate Current Procedural Terminology (CPT) code. Incorrect NDC/CPT combinations will result in claim denial.
- Providers must bill the state supplied vaccines (VCF) itself with a modifier of "SL" and the applicable administrative service code to get reimbursed for its Florida Medicaid members 18 and under.

For additional information please visit our Medical Clinical Policy (0726) Bulletin on our Clinical Policy Bulletins page: http://www.aetna.com/cpb/medical/data/700_799/0726.html

Human Papillomavirus (HPV) vaccine

Gardasil-4 (quadrivalent) vaccine is no longer available for use in the United States. The last doses expired on May 1, 2017. This vaccine has been replaced with Gardasil-9.

CPT codes 90650 and 90649 are no longer valid and have been replaced with 90651 – Gardasil 9.

If vaccination providers do not know or do not have available the HPV vaccine product previously administered, or transitioning to Gardasil 9, any available HPV vaccine product is considered medically necessary to continue or complete the three-dose series for females and males.

Cervarix bivalent HPV vaccine has been removed from the ACIP immunization schedule. This vaccine has been removed from the U.S. market, and all available vaccine doses have expired.

Clinical Claims Reviews

Clinical claims reviews

As part of ongoing policy review processes for clinical, payment and coding policy positions, Aetna Better Health of Florida will be conducting claim reviews due to a recent increase on duplicate payments.

Revenue code 370

Identifying duplicate payments for the same anesthesia service code paid to the facility and the anesthesiologist.

- Revenue Code 370 should be billed with corresponding anesthesia supplies, sedation services, or nurse monitor of sedation resources.
- Anesthesia service code should be billed by anesthesiologist

Independent Labs

Identifying duplicate payments for laboratory services when multiple individuals report services for same patient and same diagnosis code.

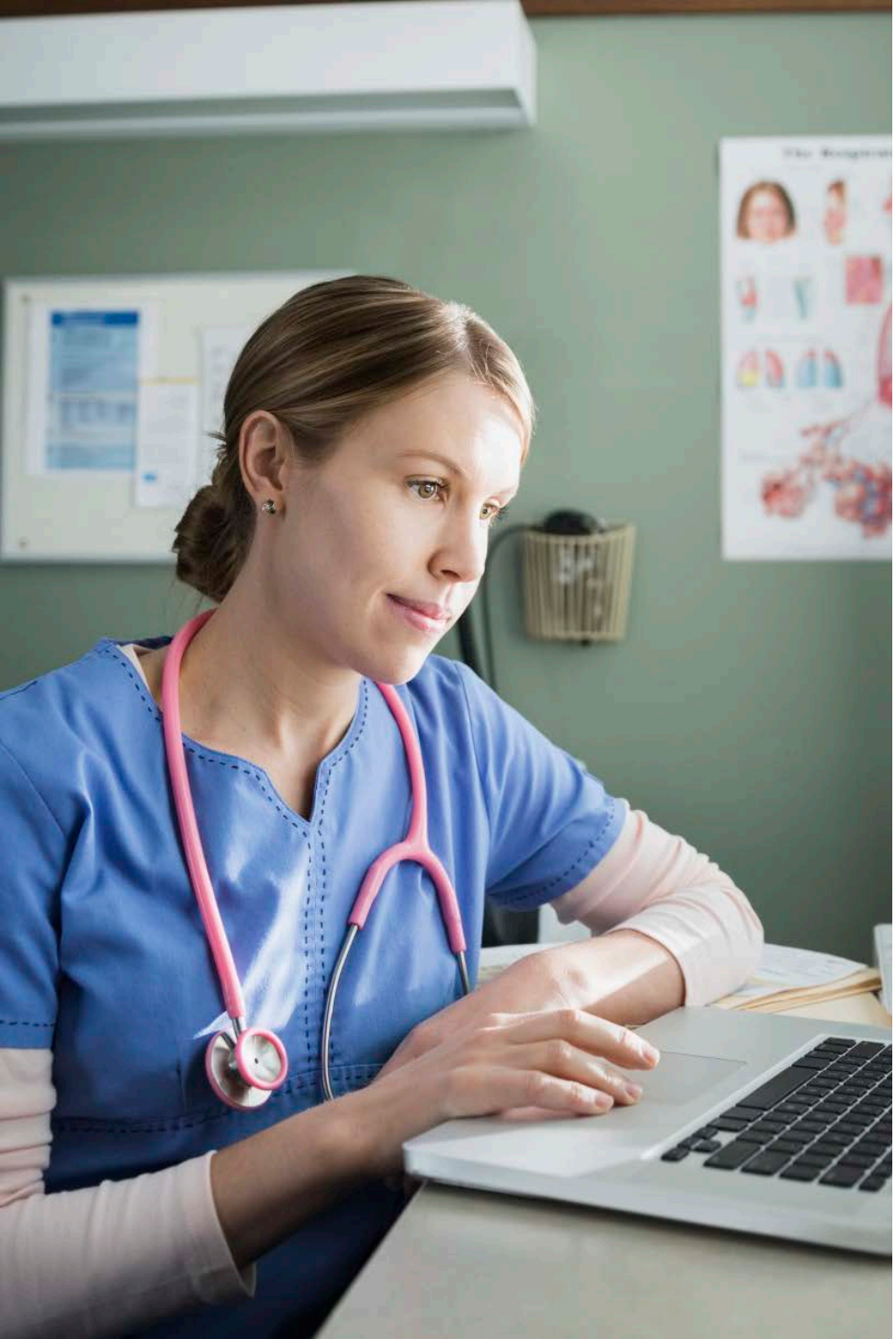
- If a reference lab bills with place of service 81 and a non-reference lab bills for the same services, only the place of service 81 is payable.
- If a pathologist or physician's office laboratory submits duplicated laboratory services, only the pathologist's service is reimbursable.

Global surgery codes

Identifying services where payment should have been included in global surgery package payment.

- The global surgical package, also called global surgery- includes all the necessary services normally furnished by the surgeon before, during, and after a procedure.
- Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician.

Obstetric PA Requirements



Obstetric (OB) prior authorization requirements

Aetna Better Health of Florida implemented changes that affects Prior Authorization (PA) requirements related to Obstetric (OB) Ultrasound codes effective May 1, 2020

- OB notifications must be sent for all newly identified pregnancies.
- For the first prenatal visit you are required to complete the Obstetrical Notification form and attach office visit notes when submitting the form. Please provide Diagnosis/ICD 10 code if available.
  - The Obstetrical Notification form can be located on our website: https://www.aetnabetterhealth.com/florida/assets/pdf/provider/Obstetrical%20Notification.pdf

aetna

Obstetric (OB) prior authorization requirements

OB Ultrasounds CPT Codes and Limits

CPT	Limits	Auth Required
76801-76812, **76815, 76816**	Up to three (3) obstetrical ultrasounds per pregnancy (any combination of codes)	• No PA required if within limits • Auth required for NON-PAR providers • Auth required if exceeding limits • Auth required for POS 22
76813	One (1) per pregnancy	• No PA required if within limits • Auth required for NON-PAR providers • Auth required if exceeding limits • Auth required for POS 22
76818	Up to two (2) per pregnancy	• No PA required if within limits • Auth required for NON-PAR providers • Auth required if exceeding limits • Auth required for POS 22

CPT Codes 76817 and 76819 require prior authorization at any place of service for both Par and Non-Par Providers.

aetna

Obstetric (OB) prior authorization requirements

When billing prenatal H codes for office visits, please remember to bill only one H code per visit. The below chart has specific information regarding CPT H1000 and H1001 visit limits and the required notifications.

Prenatal H codes for Office Visits

CPT	Limits	Notification Required
H1000	• 14 visits for normal pregnancy • 18 visits for High Risk pregnancies	OB notification must be sent for all newly identified pregnancies
H1001	Up to three (3) per pregnancy	OB notification must be sent for all newly identified pregnancies

****Auth required for all services if non par****

aetna

Common claim denials

Claim denials- provider data

- Billing or Rendering NPI is not found or is listed as inactive on the PML.
- The claim(s) denied because either the billing or rendering National Provider Identifier (NPI) is not active or does not exist in the Florida Medicaid system.
- Billing or Rendering NPI has an NPI beginning date before the claim date of service.
- The claim(s) denied because the Medicaid ID linked to the NPI was not active for the claim date of service.
- For example, NPI 1234567890 maps to Florida MCD ID 000000000, which has an NPI beginning date of 12/10/19. The date of service billed on the claim is 12/5/19. The claim will deny because 12/5/19 is before the NPI beginning date of 12/10/19.
- In some instances, the state will allow the NPI crosswalk to be back dated 1 year. Providers will need to reach out to Florida Medicaid and request they back date the NPI providers panel and the Medicaid claims eligibility panel 1 year.
- To verify the information listed on the Provider Master List (PML) visit http://portal.flmmis.com/FLPublic/Provider_ManagedCare/Provider_ManagedCare_Registration/tabId/77/Default.aspx?linkid=pml

Questions? We've got answers.

Just call our Provider Services Department at 1-844-528-5815 .

aetna®